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Issue Date: 13 February 2006

In the Matter of

HELEN M. GWINN, Widow
and
PAUL G. GWINN, Deceased Miner
Claimants

v.

WESTMORELAND COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Case Nos. 2004-BLA-05286
and 2004-BLA-05287

Appearances: James M Phemister, Esq. Mary Rich Maloy, Esq.
Peggy Japngie Lizotte For the Employer
For the Claimant

Before: William S. Colwell
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. The Act and applicable implementing regulations, 20 CFR Parts 718 and 725, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2004). In this case, the Claimant, Helen M. Gwinn, alleges, on her behalf and on behalf of her late husband, Paul G. Gwinn, that he was totally disabled due to pneumoconiosis and that his death was due to pneumoconiosis.

I conducted a hearing on these claims on January 19, 2005 in Beckley, WV. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2004). At the hearing, Director's Exhibits ("DX") 1-12, 14-50, and 54-80, Administrative Law Judge Exhibit ("ALJX") 1, Claimant's Exhibits ("CX") 1-3, and Employer's exhibits 1, 2, 4, 5, 7, and 8 were admitted into evidence without objection. Transcript ("Tr.") at 11, 12, 18, 19, 21, 23. Claimant objected to DX 13, 51, 52, and 53, and EX 3 and 6. Tr. 14-15, 24. I rule that DX 51 and 53 are not admitted into evidence, since they exceed the evidentiary limitations of § 725.414, and I do not find good cause has been established to exceed the evidence limitations. I did not allow EX 6 to be admitted. Tr. 24. However, I have attached all excluded exhibits to the record for review by appellate authority. I informed the parties that I would address the objections to DX 13 and 52, as well as EX 3 in this decision.

Claimant objected to DX 13, specifically interpretations of June 6, 1997 and June 30, 1998 x-rays by Dr. Wiot, on the basis that they exceed the evidentiary limitations. DX 13 also included x-ray readings by Dr. Wiot for x-rays taken on August 30, 2001 and November 21, 2001. Employer countered that good cause existed for their consideration, and that they rebutted the Department of Labor evidence, because the original x-rays were part of Dr. Rose's treatment records. I find that good cause does not exist for the submission of the additional x-rays of Dr. Wiot. Of these four readings in Dx 13, I will consider only the x-ray taken November 21, 2001 and reread by Dr. Wiot on January 30, 2002. This reading is properly listed on the Employer's Evidence Summary Form to be considered as one of its two x-ray readings. Moreover, I will not consider the hospital x-rays as part of the x-ray evidence, because they have not been offered as such and do not substantially comply with the quality standards of § 718.102. Therefore, Claimant's objection is sustained for the additional Dr. Wiot x-ray readings, other than the one identified above.

Director's exhibit 52 and Employer's exhibit 3 are Dr. P. Raphael Caffrey's October 24, 2002 report and May 19, 2003 supplemental report, respectively. They are offered by the Employer as pathology reports regarding the biopsy of Mr. Gwinn's right lower lung lobe. As part of the original report, Dr. Caffrey also reviewed the claim form, answers to interrogatories, medical reports from the West Virginia Occupational Pneumoconiosis Board, the Charleston Area Medical Center, Dr. Rasmussen, and Dr. Zaldivar, a hospital discharge summary, the death certificate, and Dr. Naeye's pathology report. The supplemental report was based on review of Dr. Bush's consultation report, which I have not admitted into evidence, and Dr. Rasmussen's March 12, 2003 report. Claimant argues that because Dr. Caffrey's report is based not only on his review of the biopsy slides and biopsy report, it really constitutes a third reasoned medical opinion and, thus, exceeds the evidentiary limitations. Having considered the positions of the parties, I find Claimant's argument meritorious.

Section 725.457(d) is instructive. It states that a physician whose testimony is permitted "shall not be permitted to testify as to any medical evidence relevant to the

miner's condition that is not admissible." This applies to medical reports as well as live witnesses. A physician performing a record review cannot consider evidence that is not part of the record; he cannot bring in through the back door evidence that is not otherwise admissible, and a fact-finder should strike that part of the physician's opinion that considers inadmissible evidence. In this matter, §725.414 limits the Employer to two medical opinions and no more than one physician's interpretation of each biopsy report submitted by the Claimant. Employer has selected the medical reports of Drs. Castle and Zaldivar. Dr. Caffrey's report can only be considered insofar as it interprets the biopsy evidence. Accordingly, Claimant's objection to EX 3 is sustained, and I will consider DX 52 only insofar as it addresses the biopsy evidence. Any part of Dr. Caffrey's report that relies upon review of any other evidence will not be considered.

Claimant was allowed to respond to Dr. Castle's report because of its late submission. Tr. 29-30. On February 18, 2005, I received proposed CX 4 and CX 5. Claimant's exhibit 4 is the supplemental report of Dr. Rasmussen, and CX 5 is the supplemental report of Dr. Cohen. These reports were received and are marked CX 4 and CX 5, respectively, and admitted into evidence. The parties also submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Miner, Paul G. Gwinn, filed his initial claim on November 7, 1995, and the claim was denied by Administrative Law Judge James W. Kerr, Jr. in a decision and ordered rendered September 5, 1997. Judge Kerr found that the Miner had failed to establish both the existence of pneumoconiosis and that his total disability was due to pneumoconiosis. He did, however, find that the Miner was totally disabled. DX 1.

No further action was taken until Mr. Gwinn filed a second claim on April 24, 2001. DX 3. In a Proposed Decision and Order dated April 7, 2003, the District Director awarded benefits. DX 24. The Employer requested a hearing on April 15, 2003. DX 26. In the meanwhile, Mr. Gwinn died on March 23, 2002, and Mrs. Gwinn filed a claim for survivor's benefits on May 13, 2002. DX 34. The District Director issued a Proposed Decision and Order awarding Mrs. Gwinn benefits on August 29, 2003. DX 65. Employer requested a hearing on September 5, 2003, DX 67, and the claims were referred to this office on November 14, 2003. (DX 75, 76).

APPLICABLE STANDARDS

Since this claim was filed after January 19, 2001, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2004). In order to establish entitlement to benefits under Part 718, the Claimant must establish that the Miner suffered from pneumoconiosis, that his pneumoconiosis arose at least in part out of his

coal mine employment, that he was totally disabled, and that the pneumoconiosis was a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004). In the widow's claim, she must also establish that pneumoconiosis caused his death. § 718.205.

ISSUES

After the hearing, the following are the remaining contested issues:

1. Whether the Miner's claim was timely filed.

2. Whether the Miner suffered from pneumoconiosis.

3. Whether the Miner's pneumoconiosis arose out of his coal mine employment.

4. Whether the Miner was totally disabled.

5. Whether the Miner's disability was due to pneumoconiosis.

6. Whether the Miner has demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final, pursuant to § 725.309(d).

7. Whether the Miner's death was due to pneumoconiosis.

DX 75, 76; Tr. 7. (Employer conceded that Mr. Gwinn was a miner who was employed after 1969, that he worked 22 years with Westmoreland Coal Company, that it is the responsible operator, and that Mrs. Gwinn is his eligible survivor and dependent. Tr. 7)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified to the following. Tr. 1-44. The Miner was born August 19, 1926, and died March 23, 2002. Mrs. Gwinn was born December 24, 1930, and married the Miner on May 20, 1950, and they were married for fifty-one years at the time of his death. Tr. 23. She has not remarried.

According to Mrs. Gwinn, Mr. Gwinn worked as a hand loader, a continuous miner operator, an electrician, and finally a manager. He retired in 1986 from Westmoreland Coal Company, and that was his last coal mine employment. She testified that all of his work was underground, and he worked a lot of overtime. He was covered with dust when he came home each day.

Regarding the Miner's health, Mrs. Gwinn stated that his problems began in 1986 when he began having difficulty breathing. His chest burned and felt tight. He coughed and was exhausted. His condition progressively worsened, and he was put on oxygen to help him sleep. Mr. Gwinn had other health problems, including atrial fibrillation which required heart medicine, a heart catheterization in 2000, and the placement of stents in his kidneys. He was diagnosed with lung cancer on March 18, 2002, and died three days later. Mrs. Gwinn testified that she could not recall what the Miner's smoking history was or when exactly he quit, but she believed that he quit five to eight years prior to their moving into their house in 1977.

Claimant's last coal mine employment was in West Virginia. DX 4. Therefore this claim is governed by the law of the 4th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner." 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001).

For this case, the Employer contends that the Miner's claim was not timely, because it was not filed within three years of a medical determination of total disability due to pneumoconiosis. Specifically, the Employer relies upon Mrs. Gwinn's statement that in 1995 her husband was told by a doctor that he was totally disabled due to black lung disease. Employer points out that Dr. Rasmussen examined the Miner that very year. Employer further relies upon testimony of the Miner from 1987 in which he stated that Dr. Dunbar told him in 1986 that he was disabled due to his breathing.

First, I do not find that Dr. Dunbar's statement is equivalent to a communication that the Miner was totally disabled due to pneumoconiosis. Secondly, the hearing testimony to which the Employer refers follows:

> Q. Do you have any memory of any, and you might not be able to answer this. So just let me know. I need to know if you are aware of any doctor ever telling Mr. Gwinn that he had Black Lung and was totally disabled because of Black Lung.
> A. Yes.
> Q. Can you tell me the earliest date that he was given that information?
> A. I'm not exactly, but I think it was 1995.

Tr. 38-39. Mrs. Gwinn did not state which physician told her husband that he was totally disabled due to pneumoconiosis. She was not certain that such a communication occurred in 1995. Moreover, unless Mrs. Gwinn was also present when the communication took place, her testimony is hearsay. I simply do not find this testimony sufficient to establish by a preponderance of the evidence that a medical determination of total disability due to pneumoconiosis was communicated to the Miner more than three years prior to the filing of the current claim. Thus, I find this claim is timely.

Length of Coal Mine Employment

Westmoreland Coal Company conceded 22 years of coal mine employment. Tr. 7. Mr. Gwinn alleged over 38. DX 3. The Social Security records confirm the following additional, non-overlapping coal mine employment: 2 quarters with Alaska Coal Company in 1947 and 1948; 16 quarters with Johnstown Coal & Coke Company from 1948 through 1952; 1 quarter with New River & Poca Cons. Coal Company in 1950; 8 quarters with Wilpen Coal Company from 1953 through 1955; 7 quarters with Mount Hope Coal Company from 1955 through 1957; 13 quarters with Midland Coal Company from 1955 through 1958; 16 quarters with Peaser Branch Coal Company from 1957 and 1960 through 1964; and 21 quarters with Imperial Smokeless Coal Company from 1964 through 1971. DX 4. Based on the additional evidence, I credit the Miner an additional 21 years of coal mine employment, for a total of 43 years of coal mine employment.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations are found at 20 CFR § 718.102 (2004) and Appendix A of Part 718. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004).

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute

of Occupational Safety and Health (NIOSH).[1] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray/ reading	Readers' Qualifications (all are doctors)	Reading and Film Quality	Result Concerning Presence of Pneumoconiosis
DX 11 8/30/01/ 9/13/01	Patel B, BCR	2/2/Quality 2	Positive(OWCP evaluation)
DX 11 8/30/01/ 12/4/01	Gaziano B	Quality 1	Used by District Director for quality reading only[2]
EX 8 8/30/01/ 3/29/02	Spitz B, BCR	Negative; previous coronary bypass; linear strands at lung bases; small basilar irregular densities/ Quality 2 overexposed	Negative (Rebuttal to DX 11)

[1]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

[2] Used by the District Director (DD) for a quality reading only. This reading was not submitted or mentioned by either party; and thus, I will not consider it other than as a reading for film quality.

Date of X-ray/ reading	Readers' Qualifications (all are doctors)	Reading and Film Quality	Result Concerning Presence of Pneumoconiosis
DX13 11/21/02 1/30/02	Wiot B, BCR	Negative; severe bibasilar and mid zone interstitial fibrosis with minimal changes in the right upper lung field; distribution is totally against CWP; there are no definite plaques to support diagnosis of asbestosis; most common cause of this type of interstitial fibrosis is idiopathic pulmonary fibrosis; Quality 3	Negative

Pulmonary Function Tests

Pulmonary function tests (PFT) are performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. If there is greater resistance to the flow of air, then there is more severe lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for PFTs are found at 20 CFR § 718.103 (2004) and Appendix B. The following chart summarizes the results of the PFTs available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary test, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Test Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 11 8/30/01 Rasmussen	75 66”	2.85	3.70	77%	104	No	Good cooperation and understanding
DX 12 11/12/01 Zaldivar	75 66”	2.22	2.78	80%	72	No	Mild restriction of vital capacity and total lung capacity; severe diffusion impairment

Arterial Blood Gas Studies

Arterial blood gas (ABG) studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies are found at 20 CFR § 718.105 (2004). The following chart summarizes the arterial blood gas studies available in this case. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically not advisable. 20 CFR § 718.105(b) (2004).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 11	8/30/01	Rasmussen	38 38	70 58	No Yes	Moderate to severe impairment of oxygen transfer

CT Scans

Mr. Gwinn underwent a CT scan on December 15, 2000. DX 47. Dr. Heather Rose interpreted it as showing emphysema and fibrosis but no suspicious parenchymal mass. She noted honeycombing at the bases bilaterally.

On October 19, 2001, Dr. Radoslav S. Nicholas read a CT scan of the same date. DX 47. He detected an irregular nodular density of the right lower lobe since the previous examination, as well as severe bullous emphysema.

Dr. Rose read a third CT scan on December 3, 2001. DX 47. It showed "en plaque 3 cm. mass at the right lung base." She found it difficult to say whether it was a pleural-based lesion or a lung-based lesion. She also found fibrosis and emphysematous bulla at the lung bases.

Mr. Gwinn underwent another CT scan on March 18, 2002. DX 47. Dr. Rose's findings were: (1) a worsening mass and lymphadenopathy, with a new liver mass; and (2) diffuse alveolar opacities significantly worse, with possible lymphangitic spread. She detected emphysematous changes with fibrosis, most pronounced in the bases and markedly worse since the December 3, 2001 exam.

Biopsy Evidence

Dr. Manuel Gomez examined biopsied lung tissue obtained on November 2, 2001. DX 47. The gross description included tannish-grey friable and hemorrhagic appearing tissue. The microscopic description included congestion.

Dr. P. Raphael Caffrey reviewed the biopsy report and slides and provided his opinion on October 24, 2002. DX 52. As mentioned above, only that part of his report that addresses the biopsy evidence will be considered. Microscopically he found a mild amount of anthracotic pigment but no associated fibrosis. He saw numerous macrophages, some of which contained pigment but no evidence of pulmonary fibrosis within the alveoli. Nor did he identify any asbestos bodies, birefringent crystals, or carcinoma. His final diagnoses were: (1) a mild amount of anthracotic pigment; and (2) no definite evidence of coal workers' pneumoconiosis, asbestosis, or carcinoma. Dr. Caffrey is board certified in anatomical and clinical pathology.

Medical Opinions

Dr. Rasmussen

Dr. D.L. Rasmussen examined the Miner on behalf of the Department of Labor, OWCP, on August 30, 2001. DX 11. He considered symptoms of shortness of breath with exertion for over 15-20 years, a chronic productive cough, and some tightness of the chest; a medical history significant for coronary artery bypass grafting in 2000; a history of smoking one pack of cigarettes a day from 1944 to 1980; and 38-40 years of coal mine employment, lastly as a shift foreman. Physical examination showed minimally reduced breath sounds and scattered inspiratory squeaks. He also reviewed the results of an x-ray read by Dr. Patel, a pulmonary function study, an EKG, and a blood gas study. Based on the x-ray, he felt that the abnormalities were more consistent with an interstitial lung disease such as asbestosis or idiopathic pulmonary

fibrosis. He added that the presence of diffuse interstitial fibrosis does not exclude the presence of underlying coal workers' pneumoconiosis since both can coexist. He referred to a 1988 article by McConnochie for the proposition that coal miners develop interstitial fibrosis at a considerably greater rate than the normal population although the disease seems to be somewhat more moderate and the survival usually longer. This study also showed that about 18% of US and Welsh miners develop interstitial fibrosis. Dr. Rasmussen is board certified in internal medicine.

Dr. Rasmussen also provided a supplemental report at the request of the Miner's attorney on November 2, 2004. CX 1. He considered the CT scan reports of December 15, 2000, October 29, 2001, December 3, 2001, and March 18, 2002; pulmonary function studies from March 20, 2001, August 30, 2001, and November 21, 2001; and the reports of Drs. Baldwin, Stewart, and Zaldivar. He opined that the data did not alter his opinion that Mr. Gwinn suffered from a disabling and ultimately fatal lung disease caused by his forty years of coal mine dust exposure. He again referred to the McConnachie study and responded to Dr. Zaldivar's criticisms. He stated that the studies showed a high incidence of interstitial fibrosis among coal miners in the U.S., United Kingdom, France, and Japan and those exposed to welding fumes. He explained that the chemical mechanism of how coal dust exposure causes diffuse interstitial fibrosis is not fully understood, but it works in the same manner as asbestos and silica exposure do. He reiterated that interstitial fibrosis occurs much more in coal miners than in the general population.

Dr. Rasmussen provided a further supplement to his report on February 7, 2005, after reviewing Dr. Castle's report and deposition. CX 4. He again opined that diffuse interstitial fibrosis is far more prevalent in coal miners than in the general population. He added that a person can have both coal workers' pneumoconiosis (CWP) and diffuse interstitial fibrosis. His opinion that the Miner had a disabling and fatal lung disease due in major part to his forty years of coal dust exposure remained unchanged.

Dr. Zaldivar

Dr. George L. Zaldivar examined the Miner at the Employer's request on January 21 2001. DX 12. He considered symptoms of shortness of breath for 15-20 years, the need to be on oxygen, difficulty walking, some wheezing and cough with sputum production, ankle edema, and tightness in the chest; a medical history significant for coronary bypass surgery in 2000; a history of having smoked one and one-half packs of cigarettes a day from childhood until the age of 55; and a 40-year history of coal mine employment. Dr. Zaldivar also elicited that Mr. Gwinn was in the Navy for two years, and for the last year of his service, he worked as an electrician. He noted, "He says that he did not have to do any work with asbestos, although he did work in the boiler room." Physical examination revealed inspiratory crackles bilaterally. He also reviewed other medical evidence, including multiple x-ray reports dating back to 1987, 1995 CT scan reports, and the reports of Drs. Castle, Stewart, Loudon, and Fishman. Dr. Zaldivar found no evidence of coal workers' pneumoconiosis. He ruled out CWP, because it causes an obstructive impairment but Mr. Gwinn demonstrated a purely restrictive

impairment and because of the presence of bullae on the CT scan. However, Dr. Zaldivar did see radiographic evidence of pulmonary fibrosis accompanied by pleural thickening which he felt was most likely due to asbestosis or surgery. Dr. Zaldivar stated that the Miner had a history of asbestos exposure when he was an electrician in the Navy. He worked in the ship's boilers which were typically insulated with asbestos. Dr. Zaldivar reasoned that if the Miner had to strip any of the asbestos to get to the wiring, he was exposed to asbestos and may have inhaled enough to produce pulmonary fibrosis now. He explained that the latency for pulmonary fibrosis and pleural thickening related to asbestos is a minimum of twenty years. Dr. Zaldivar further explained:

> Radiographically, the only differentiation that can be made between asbestosis and other causes of pulmonary fibrosis is the presence or absence of pleural thickening. Asbestosis is always accompanied by pleural thickening because the pleura is also affected by the asbestos fibers resulting in thickening. Pulmonary fibrosis of other causes do [sic] not affect the pleura. In this instance, the pleura did not appear to be affected until after the cardiac surgery. In surgery, there are chest tubes inserted which cause scarring in the pleura which may well be the cause of the current fibrosis of the pleura which was not present before. If such is the case, then the pulmonary fibrosis which I am now seeing is not the result of asbestosis, but the result of an idiopathic process complicated by pleural thickening from surgery. In any case, the radiographic changes are not due to coal worker[s'] pneumoconiosis.

He also diagnosed anemia, a mild restriction of vital capacity, a mild to moderate restriction of total lung capacity without air trapping, and severe diffusion impairment. Dr. Zaldivar described the pulmonary impairment as severe due to restriction of the lungs caused by the fibrosis and diffusion impairment caused by fibrosis. He did not relate any impairment to coal mine employment. Dr. Zaldivar also found the Miner was totally disabled due to his cardiac and vascular disease due to atherosclerosis.

Dr. Zaldivar provided a supplemental report dated March 1, 2002. DX 13. He reviewed Dr. Rasmussen's August 30, 2001 report. He provided his comments on the medical articles on which Dr. Rasmussen relied. Dr. Zaldivar stated that the 1988 McConnochie article revealed nothing. It involved 43 patients, 19 of whom had lung tissue taken and 23 of whom were deceased. Of those, autopsies were performed on 19, but only one had not smoked at some time. Coal dust pigmentation was found in the samples, but coal workers' pneumoconiosis was not identified in any of the samples. The 1997 American Journal of Respiratory and Critical Care Medicine article had not been subject to peer review to determine its validity, and, according to Dr. Zaldivar, does not even imply that coal workers have any greater incidence of pulmonary fibrosis than the general population. Dr. Zaldivar referred to a 2001 article by Drs. Ryu and Colby that concluded that smokers develop pulmonary fibrosis by the mere fact that they smoke. Dr. Zaldivar again found that there was no evidence to justify a diagnosis of coal workers' pneumoconiosis. He pointed out that large opacities of coal workers'

pneumoconiosis always appear in the upper lobes or mid zones but do not occur in the lower lobes, as found by Dr. Patel when he read the August 30, 2001 x-ray. He again found that Mr. Gwinn was totally disabled from a pulmonary standpoint due to his pulmonary fibrosis unrelated to coal workers' pneumoconiosis. Dr. Zaldivar is board certified in internal medicine, pulmonary diseases, sleep disorder medicine, and critical care medicine.

Dr. Zaldivar provided a third report dated May 19, 2003. EX 1. He considered Dr. Wiot's review of x-rays between 1997 and 2002 as well as his CT scans of 1995 and 2000; the readings of Drs. Spitz and Meyer of the November 21, 2001 x-ray; the biopsy report of Dr. Gomez; the death certificate; Dr. Naeye, Dr. Caffrey, and Dr. Bush's reports related to the biopsy; and Dr. Rasmussen's March 2003 report. Dr. Zaldivar referenced a 1998 article by Katzenstein and Myers in which there is no mention of coal workers' pneumoconiosis causing pulmonary fibrosis. He again criticized the McConnochie article and this time stated that diffuse black pigmentation was found in only 7.6% of the 23 autopsied lungs. He added that this finding is not specific for any disease. He concluded that the authors stated that the 45 miners in their study had pulmonary fibrosis, but no link could be established with coal workers' pneumoconiosis. Dr. Zaldivar cited a1995 article entitled *Criteria for a Recommended Standard: Occupational Exposure to Respirable Coal Mine Dust* which found that residual volume and total lung capacity are elevated in CWP patients, while FEV1 and FVC are reduced. In Mr. Gwinn's case, his total lung capacity and residual volume were both below normal, while his FEV1 was normal and his FVC was only mildly reduced. Therefore, he concluded that this pattern does not fit into those described for CWP affecting pulmonary functions but fits very will with the diagnosis of pulmonary fibrosis of the idiopathic variety. Consequently, Dr. Zaldivar concluded both that Mr. Gwinn has no evidence of CWP and that there is no medical literary link between CWP and pulmonary fibrosis. He described idiopathic pulmonary fibrosis as a common disease, occurring in one of every 10,000 people over age 55 in the United States, and cigarette smoking predisposes one to it.

Dr. Zaldivar was deposed on January 4, 2005. EX 4. He testified that he first diagnosed asbestosis because there was no biopsy evidence. After reviewing the biopsy report, he stated that it was not diagnostic. There was not enough lung tissue to even show fibrosis or cancer. After reviewing even more medical data, Dr. Zaldivar testified that there was no solid evidence to establish cancer. Still, he deposed that the Miner died of cancer. He added that pulmonary fibrosis played a role in the Miner's general disability and contributed to his ill health and, to some extent, his death, but coal dust exposure did not.

Dr. Zaldivar testified that a restrictive defect is associated with pulmonary fibrosis, and that pneumoconiosis only causes restriction when it is progressive massive fibrosis, which the Miner did not have. The Miner's mass was fast growing, typical of cancer but not CWP. Dr. Zaldivar testified that coal dust does not cause fibrosis and that there is no increase in pulmonary fibrosis in coal miners as compared to the general population.

Dr. Zaldivar disagreed with Dr. Cohen's statement that IPF progresses quickly. He opined that it can progress slowly and go on for more than a decade, although a patient usually dies within one to three years from diagnosis. Based on the records, he could not say that Mr. Gwinn had pulmonary fibrosis in 1987, because there was no finding of inspiratory crackles or clubbing or a diffusion abnormality. He agreed that Mr. Gwinn did not develop a severe restriction until near his death. He also stated that IPF comprises 80% of all fibroses.

Dr. Cohen

Dr. Robert A. C. Cohen, who is board certified in internal medicine and pulmonary disease, reviewed the medical evidence on behalf of the Claimant on November 12, 2004. CX 2. He reviewed the Miner's coal mine employment history, a smoking history of 39-78 pack years, the reports of Drs. Rasmussen from 1995 and 2001, the reports of Dr. Zaldivar, Baldwin, Castle, Fino, Stewart, London, Grey, Sams, Caffrey, and Bush, and the depositions of Drs. Rasmussen, Fishman, and Castle. He also reviewed x-ray readings of films dated between August 4, 1995 and March 21, 2002, CT scan reports from August 1995 to March 2002, blood gas and pulmonary function studies from August 1985 to March 2002, the death certificate, hospital records, and the biopsy report.

Dr. Cohen opined that the Miner had coal workers' pneumoconiosis because: (1) he had 38 years of exposure to coal dust; (2) although he had a significant smoking history, it causes an obstructive impairment, while the Miner's impairment was restrictive; (3) he had symptoms of shortness of breath and a cough; (4) his pulmonary function study showed a restrictive impairment when the TLC was measured, a diffusion impairment since 1995, and this impairment is due to pulmonary fibrosis; (5) he had a significant gas exchange abnormality; and (6) the x-rays and CT scans showed interstitial lung disease and fibrosis. Dr. Cohen stated that British studies from 1976 and 1983 show that irregular opacities are associated with CWP.

Dr. Cohen further testified that in order to diagnose idiopathic pulmonary fibrosis, there should be an absence of any exposure to something causing lung scarring. In this case, the Miner was exposed to coal dust, and his fibrosis progressed gradually, beginning in 1987. Idiopathic pulmonary fibrosis, on the other hand, is a much more rapidly developing condition and is associated with very severe restrictive defects. Mr. Gwinn's restrictive impairment was not severe until near the end of his life. Dr. Cohen cites articles reporting that coal miners with classic IPF, and Dr. Zaldivar relied on these.

In his opinion, the Miner was totally disabled from performing his last job as a foreman due to CWP. He also believes that CWP hastened the Miner's death, because Mr. Gwinn did not have normal lungs and could not withstand the further insult to his respiratory system of his lung cancer. The Miner did not have normal pulmonary reserve due to his lung disease caused by coal dust exposure.

After considering Dr. Castle's opinion, Dr. Cohen provided a supplemental report. CX 5. He stated that Dr. Castle failed to explain how dust exposure was not a factor in the Miner's development of pulmonary fibrosis. He believes Dr. Castle is wrong in saying that coal mine dust-induced impairment must have an obstructive and restrictive impairment; there is no support for that statement. He also stated that Dr. Castle is wrong when he says that irregular opacities cannot occur with coal dust exposure. Regarding pulmonary fibrosis, Dr. Cohen testified that Dr. Castle did not deal with the Miner's significant exposure and how this fibrogenic dust had no effect on his fibrotic lung disease.

Dr. Castle

Dr. James R. Castle reviewed medical evidence, at the request of the Employer, on December 28, 2004. EX 2. He considered more than 38 years of coal mine employment, a 39-pack-year smoking history, his prior report of August 1996, Dr. Fino's 1997 report, Dr. Stewart's 1997 report, Dr Rasmussen's 1997 deposition and 2001 report, Dr. Loudon's 1997 report, Dr. Fishman's 1997 deposition, Dr. Zaldivar's 2002 reports, hospital records from December 2000 and March 2001, x-ray reports of x-rays taken between June 25, 1996 and November 21, 2001, and August 8, 1995 and December 15, 2000 CT scan reports. Dr. Castle concluded that the Miner did not have coal workers' pneumoconiosis. He cited the following risk factors for the development of pulmonary disease in the Miners' case: 40 years of coal mine employment; his smoking history; usual interstitial pneumonitis (UIP) or idiopathic interstitial pulmonary fibrosis (IPF), and cardiac disease. He found the presence of crackles or crepitations on some occasions was indicative of interstitial pulmonary fibrosis. He opined that there was radiographic and CT scan evidence of an interstitial fibrotic process in the lower lung zones that is typical of that seen with UIP or IPF but not CWP which typically causes small, round, regular opacities in the upper lung zones. He further opined that Dr. Zaldivar's pulmonary function testing showed a mild restrictive lung disease without obstruction but with a severe reduction in the diffusing capacity that is entirely typical of UIP or IPF but not CWP. CWP, he explained, generally causes a mixed, irreversible obstructive and restrictive ventilatory defect. Dr. Castle felt that the Miner is totally disabled from a pulmonary process—UIP or IPF—but not a coal mine dust induced lung disease or CWP. Dr Castle is board certified in internal medicine and pulmonary disease.

Dr. Castle was deposed on January 10, 2005. EX 5. He reviewed additional medical evidence, including the reports of Drs. Zaldivar, Caffrey, Cohen, and Rasmussen, and hospital records from March 2002. He again did not find CWP. He explained that IPF is a restrictive pulmonary process associated with a reduction in diffusion capacity and rales, crackles, or crepitations. He stated that there is no connection between coal dust exposure and IPF. In his opinion, the Miner died from lung cancer, and coal mine dust exposure played no role in his death. Dr. Castle disagreed with Dr. Cohen's statement that pulmonary fibrosis is always rapidly progressing; he testified that most of the time it progresses slowly, and the restriction

does not have to be severe. Dr. Castle allowed that CWP can cause a reduced diffusion capacity. He also opined that Mr. Gwinn was totally disabled.

Hospital Records

Mr. Gwinn was hospitalized at the Charleston Area Medical Center on December 28, 2000, for chest tightness. He was attended by Dr. John Goad at that time. DX 15. He was also hospitalized from March 6-7, 2001, under the care of Dr. Mark C. Bates for renal artery stenosis.

The record also shows that Mr. Gwinn was hospitalized at Greenbriar Valley Medical Center from January 12-16, 2001, when he was attended by Dr. Sams. He complained of chest pain. He was again admitted on October 27, 2001, and stayed until November 3, 2001, again under the care of Dr. Sams.

Mr. Gwinn was hospitalized from March 18, 2002 to March 23, 2002, the date of his death. Dr. Sams attended him, and during that stay, he was seen by Drs. Richard R. Durham, J. Jay Baker, and Edward J. Grey. EX 7. Dr. Durham noted that the Miner had been admitted for hypoxemic respiratory failure. He believed it was probably a manifestation of his COPD, possibly secondary to primary lung cancer with metastases. Dr. Durham noted a history of CWP. Dr. Baker diagnosed probable pulmonary malignancy with hepatic metastases and Black Lung. Dr. Grey took smoking, medical, and employment histories and considered the results of x-rays, CT scans, and a pulmonary function study. Physical examination showed crackles in the bases. He diagnosed dyspnea on exertion most likely due in part to sub-pleura fibrosis with some emphysema. He assumed the x-ray changes were secondary to interstitial lung disease, perhaps related to occupational lung disease or idiopathic fibrosis. Dr. Sams' final diagnoses included: (1) malignant neoplasm of the upper lobe of bronchus; (2) secondary malignant neoplasm of the liver; (3) secondary unspecified malignant neoplasm of the intrathoracic lymph nodes; (4) acute respiratory failure; (5) chronic airway obstruction; (6) atrial fibrillation; (7) CWP; (8) coronary atherosclerosis of native coronary vessels; (9) peripheral vascular disease; (10) unspecified disorders arteries and arterioles; and (11) peptic ulcer disease.

Treatment Records

The record contains the progress notes from Dr. Debra Sams, Mr. Gwinn's treating physician, from July 14, 1995 to March 18, 2002. DX 47. They show that she regularly examined him and considered x-rays, CT scans, and other objective data, and that she followed him during hospitalizations and was kept aprised of his condition by consulting physicians. She diagnosed, among other things, chronic obstructive pulmonary disease/emphysema and Black Lung.

Dr. Sams provided a letter dated August 27, 2002, in which she explained that Mr. Gwinn had been her patient since July 14, 1995, at which time she diagnosed him with Black Lung. She treated him regularly thereafter until his

death. Although the Miner's primary cause of death was lung cancer, Dr. Sams felt that pneumoconiosis also contributed to his death.

Death Certificate

Mr. Gwinn died on March 23, 2002, and Dr. Sams completed the death certificate. DX 42. She listed the cause of death as respiratory failure due to black lung and cancer of the lungs with probable metastases to the liver.

DISCUSSION AND APPLICABLE LAW

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the

subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d) (April 1, 2002).

The Miner's most recent prior claim was denied after an administrative law judge determined that he failed to establish the existence of pneumoconiosis and that his totally disabling respiratory condition arose, in whole or in part, out of his coal mine employment. Therefore, in order for the Miner to avoid having his subsequent claim denied on the basis of the prior denial, he must establish one of these elements through newly submitted evidence.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2004).

20 CFR § 718.202(a) (2004) provides that a finding of the existence of pneumoconiosis may be based on evidence from a (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions (not applicable here) described in Sections 718.304, 718.305, or 718.306, or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. In order to determine whether the evidence establishes the existence of pneumoconiosis, I must consider the chest x-rays and medical opinions – the two categories of evidence applicable in this case. As this claim is governed by the law of the Fourth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 718.202(a). *See Ferguson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the four available x-ray readings in this case, two were considered negative for pneumoconiosis while one was found to be positive, and one was read for quality purposes only. For cases with conflicting x-ray evidence, the regulations specifically provide,

Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2004); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991).

Readers who are board-certified radiologists and/or B readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Scheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52. Finally, a radiologist's academic teaching credentials in the field of radiology may be relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See Worhach v. Director*, *OWCP*, 17 B.L.R. 1-105, 1-108 (1993).

Analysis of X-Ray Studies

The August 30, 2001 x-ray was found positive by Dr. Patel, with a reading of 2/2. Dr. Patel is both a B-reader and a board-certified radiologist. Dr. Spitz reread the film as negative for pneumoconiosis. Both he and Dr. Patel felt it was a quality 2 film. Dr. Gaziano, a B-reader, read the film for quality purposes only and found it to be quality 1. Because the credentials of Drs. Patel and Spitz are equal, and they agreed as to the film's quality, I find that this film fails to establish by a preponderance of the evidence the existence of pneumoconiosis. *Scheckler*, 7 BLR 1-128.

The November 21, 2001 x-ray was found negative for pneumoconiosis by Dr. Wiot, a B-reader who is also a board certified radiologist. It was not reread. He felt the film was quality 3. Because his reading is uncontroverted, I consider this x-ray to be negative for the disease.

In summary, there are one positive and two negative x-ray readings. All three readers have the same qualifications for x-ray interpretation. I conclude that the x-ray evidence fails to establish, by a preponderance of the evidence, the existence of pneumoconiosis.

Analysis of Biopsy Evidence

The biopsy evidence does not establish the existence of pneumoconiosis. The tissue sample was insufficient to provide any definite diagnoses, including the Miner's cancer. Dr. Caffrey noted a mild amount of anthracotic pigment, but a finding of anthracotic pigmentation is not sufficient, by itself, to establish the existence of pneumoconiosis. § 718.202(a)(2). Neither Dr. Gomez, the hospital pathologist, nor Dr. Caffrey, the reviewing pathologist, found definite evidence of coal workers' pneumoconiosis. Therefore, I conclude that the biopsy evidence does not establish the existence of pneumoconiosis.

Analysis of Medical Opinions

Medical Opinion Guidance

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2004). The Sixth Circuit has interpreted this rule to mean that:

> in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law

and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2004) (citations omitted).

I will first address the CT scan evidence. Mr. Gwinn underwent four CT scans from the date of the last denial of his claim. None of them was read as positive for coal workers' pneumoconiosis. They do, however, document a worsening of the Miner's lung condition between December 2000 and his death fifteen months later.

Drs. Rasmussen, Cohen, and Sams diagnosed pneumoconiosis, while Drs. Zaldivar and Castle did not. Regarding Dr. Rasmussen's opinion, I note that he did not initially diagnose pneumoconiosis when he examined Mr. Gwinn on August 30, 2001. He felt the Miner had either asbestosis or idiopathic pulmonary fibrosis. It was not until his supplemental report of November 2004 that he opined that the Miner had a disabling and fatal lung disease caused by his coal mine employment. It is clear that Dr. Rasmussen's opinion is strongly rooted to the McConnachie study to which he repeatedly referred, the x-ray evidence, and the CT scans.

Dr. Cohen based his opinion on x-ray and CT scan evidence of interstitial lung disease and his opinion, based on British studies, that irregular opacities are associated with CWP. He further relied on the absence of an obstructive impairment, the presence of a restrictive impairment and diffusion impairment, and a gas exchange abnormality, as well as his belief that the Miner's condition progressed slowly. He also reasoned that because Mr. Gwinn had an exposure to a lung-scarring agent—coal dust—it was more likely the cause of the Miner's fibrosis than an unknown, unidentifiable agent.

While both Dr. Rasmussen and Dr. Cohen provide reasonable, logical bases for their conclusions, after full consideration of all the medical opinion evidence, I find the opinions of Drs. Zaldivar and Castle more persuasive. Dr. Zaldivar, for example, deconstructed the medical articles on which Dr. Rasmussen relied, explaining that they were not all peer-reviewed and did not, in fact, prove a greater relationship between IPF and coal miners than between IPF and the general population. Moreover, neither the x-rays nor the CT scans that were submitted into evidence, establish CWP, as noted above, so reliance on them further undermines Dr. Rasmussen's report. For these reasons, I discount Dr. Rasmussen's opinion.

There is clearly disagreement among Drs. Cohen, Zaldivar, and Castle as to the sort of impairment caused by pneumoconiosis. Dr. Cohen stated that it causes a restrictive impairment and smoking causes an obstructive impairment. Dr. Zaldivar opined that it causes an obstructive impairment and only causes a restrictive impairment when it is in the form of progressive massive fibrosis, which no physician diagnosed here. Dr. Castle stated that CWP generally causes a mixed, irreversible obstructive and restrictive ventilatory defect. Mr. Gwinn suffered from a restrictive defect that, toward the end of his life, was severe. Dr. Zaldivar explained how Mr. Gwinn's objective test results were typical of IPF but not CWP: his residual volume

and total lung capacity were below normal, his FEV1 was normal, and his FVC was only mildly reduced.

Although Dr. Zaldivar originally believed that Mr. Gwinn's pulmonary process was asbestosis, he later explained that he abandoned that theory, because the CT scans proved the absence of pleural thickening. I find Dr. Zaldivar's explanation logical and credible. Therefore, I do not find that his earlier belief that Mr. Gwinn had asbestosis to detract from the rest of his opinion. In fact, I find that it proves that Dr. Zaldivar is willing to change his opinion when he is confronted with contrary, persuasive evidence. Dr. Zaldivar ruled out the presence of CWP based on the x-ray evidence; the opacities were found in the lung bases, and he believes that CWP opacities always appear in the upper or mid lung zones. Regarding the medical literature, Dr. Zaldivar countered with an article that asserted that smokers like Mr. Gwinn have a greater incidence of pulmonary fibrosis simply because they smoke and another article that found no link between CWP and pulmonary fibrosis. Finally, Dr. Zaldivar explained that IPF is not rare; it comprises 80% of all fibroses and occurs in 1/10,000 US residents over the age of 55. Both he and Dr. Castle testified that pulmonary fibrosis can progress slowly, sometimes taking more than a decade. Dr. Castle deposed that it usually does progress slowly. For these reasons, including support in the form of Dr. Castle's report, I find Dr. Zaldivar's opinion to be well reasoned and place great weight on it. Moreover, I find that both Dr. Zaldivar and Dr. Castle effectively neutralized the grounds on which Dr. Cohen relied to make his finding of CWP. Therefore, I discount Dr. Cohen's opinion.

Dr. Castle's opinion is well reasoned and documented. He cited risk factors for the Miner's pulmonary disease, including his coal mine employment, cardiac disease, and smoking history. Therefore, contrary to Dr. Cohen's criticism, I find that Dr. Castle did consider and then rule out coal mine dust exposure as a cause of the pulmonary fibrosis. The CT scan and x-ray evidence showed a pattern unusual for CWP but typical of IPF. Like Dr. Zaldivar, he found the Miner's pulmonary function testing to be entirely typical of IPF but not CWP. Accordingly, I place great weight on Dr. Castle's opinion.

The treatment and hospital records reveal that Dr. Sams followed Mr. Gwinn for almost seven years. She examined him many times, treated him for his pulmonary condition, and considered the results of x-rays, CT scans, and pulmonary function studies. I find that this indicates that Dr. Sams observed Mr. Gwinn long and extensively enough to have obtained a superior understanding of his condition. Therefore, her opinion is entitled to great weight. However, because there is contrary probative evidence, I do not credit her opinion over those of Drs. Zaldivar and Castle. *Peabody Coal Co. v. Groves*, 279 F.3d 829 (6th Cir. 2002); § 718.104(d). While her diagnosis of CWP during hospital stays may have been based in part of the findings of the consulting physicians, Drs. Durham, Baker, and Grey, I note that they couched their findings of the disease in uncertain terms like "perhaps related to occupational lung disease." Because they did not have the advantage of a full review of records like Drs. Rasmussen, Castle, Cohen, and Zaldivar had, and the record does not show their

level of expertise and experience in making a diagnosis of CWP, I discount their findings.

Balancing Conflicting Medical Opinions

The Claimant has also failed to meet her burden of proof to show – by medical opinion evidence – that the Miner had pneumoconiosis. After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinions of Drs. Zaldivar and Castle for the reasons stated above.

Pneumoconiosis Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). As I have found 43 years of coal mine employment, Mr. Gwinn would be entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of coal mine employment if he had established the existence of the disease. Since he has not, this issue is moot.

Total Disability Causation

The amended regulations at 20 C.F.R. §718.204(c) (2001) contain a standard for determining whether total disability is caused by the miner's pneumoconiosis and provides the following:

> (c)(1) Total disability due to pneumoconiosis defined. A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in Sec. 718.201, is a *substantially contributing cause* of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a 'substantially contributing cause" of the miner's disability if it: (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.
>
> (2) Except as provided in Sec. 718.305 and paragraph (b)(2)(iii) of this section, proof that the miner suffers or suffered from a totally disabling respiratory or pulmonary impairment as defined in paragraphs (b)(2)(i), (b)(2)(ii), (b)(2)(iv) and (d) of this section shall not, by itself, be sufficient to establish that the miner's impairment is or was due to pneumoconiosis. Except as provided in paragraph (d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report.

20 C.F.R. §718.204(c) (2001) (emphasis added).

In its comments, the Department noted that addition of the word "material" or "materially" to the foregoing provisions reflects the view that "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause to that disability." Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,946 (Dec. 20, 2000).

In *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001), the Sixth Circuit interpreted the "materially worsens" standard at 20 C.F.R. §718.204(c) (2001). Under the facts of the case, Employer argued that the miner's chronic obstructive pulmonary disease "was primarily, if not entirely, a consequence of the estimated quarter-of-a-million cigarettes he had smoked." Said differently, Employer maintained that "there is no substantial evidence that Kirk's total disability, which was not caused by pneumoconiosis in 1988, had suddenly become caused by this disease in 1992." The court found that, under the amended regulatory provisions, the mere fact that Claimant's non-coal dust related respiratory disease would have left him totally disabled even without exposure to coal dust, this would not preclude entitlement to benefits. The court held that Claimant "may nonetheless possess a compensable injury if his pneumoconiosis 'materially worsens' this condition."

Dr. Sams did not address the causation of the Miner's disability. Dr. Rasmussen associated the Miner's total disability with his forty years of coal mine dust exposure. Dr. Cohen attributed Claimant's disability to CWP. Dr. Zaldivar opined that Mr. Gwinn's total disability was due to his cardiac and vascular disease due to atherosclerosis but not CWP. Dr. Cohen linked the Miner's total disability with UIP or IPF but not CWP.

Because I have concluded that Mr. Gwinn did not suffer from CWP, I discount the opinions of Drs. Rasmussen and Cohen. Dr. Zaldivar's opinion is reasonable based on the Miner's history of cardiac disease requiring heart surgery. I place great weight on Dr. Castle's opinion because Mr. Gwinn presented to the hospital, just prior to his death, in respiratory failure. Therefore, it is highly believable that this respiratory failure, caused by his IPF, rendered him totally disabled. I also find persuasive the conclusion of both Dr. Zaldivar and Dr. Castle that CWP played no role in causing the Miner's total disability. Therefore, I conclude that the Claimant has failed to establish that the Miner's total disability was due to CWP.

Because the Claimant has failed to establish either the existence of pneumoconiosis or that the Miner's total disability was due to pneumoconiosis, she has failed to demonstrate that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final, pursuant to § 725.309(d). Therefore, the Miner's claim for benefits must be denied.

Death Due to Pneumoconiosis

Mrs. Gwinn filed her claim on May 13, 2002. Therefore, entitlement to benefits must be established under the regulatory criteria at Part 718, as amended effective

January 19, 2001. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988). Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. An eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death; or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis; or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

§ 718.205(c).

In order to be eligible for benefits, a widow must prove that the miner's death was caused by pneumoconiosis. Although the Benefits Review Board requires that death must be "significantly" related to or aggravated by pneumoconiosis, the circuit courts have developed the "hastening death" standard which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. The new regulations also adopt this standard. § 718.203(c)(5). In order to recover benefits, a widow must prove through medical opinion evidence that pneumoconiosis hastened her husband's death in some manner.

Dr. Sams attributed death to respiratory failure due to Black Lung and cancer. Dr. Rasmussen opined that the Miner had an ultimately fatal lung disease caused by his coal mine dust exposure. I find this equivalent to a statement that the Miner's death was due to his coal dust exposure. Dr. Cohen felt that CWP hastened Mr. Gwinn's death. Dr. Zaldivar opined that the Miner died of cancer but added that pulmonary fibrosis contributed to some extent to his death. Dr. Castle believed that death was due to lung cancer and that coal mine dust exposure played no role in the death.

Because I have found that Mr. Gwinn did not have coal workers' pneumoconiosis, his widow cannot establish that the disease even hastened his death. Consequently, I find that Mrs. Gwinn has not established that pneumoconiosis hastened the Miner's death.

Summary

The preponderance of the evidence fails to establish that Mr. Gwinn's death was caused by, contributed to by, or hastened by coal workers' pneumoconiosis. Thus, survivor benefits must be denied.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimants have failed to meet their burdens to establish that Mr. Gwinn was totally disabled due to pneumoconiosis and that his death was hastened by pneumoconiosis. Consequently, they are not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. See Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimants for services rendered to them in pursuit of these claims.

ORDER

The claims for benefits filed by the Miner on April 24, 2001 and Mrs. Gwinn on May 13, 2002, are hereby DENIED.

A

WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.
WSC:dj

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services,

U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).